TV

The Day I Died

BBC 2, 5 February at 9 pm

Rating ★★

Does the whole of your life really flash across your mind in an instant as you lose consciousness while drowning? Most of us must have wondered what it is like to die since death is one of the two certainties in life, along with taxation. It might be supposed that we can never know. However, there are many people who have recovered after losing consciousness in situations in which most others would have continued to death, and it is reasonable to suppose that their last thoughts might be the same as those of patients in similar situations who do not recover.

These are commonly described as "near death experiences." Some of these, which are recalled subsequently, are surprisingly clear and detailed.

This programme is based on a number of anecdotal accounts of such experiences as well as a study from Southampton, which found 4 out of 63 patients who recovered from a cardiac arrest, and a similar Dutch study, which found 41 out of more than 300 patients.

These survivors describe remarkably consistent phenomena—it is apparently pleasurable, peaceful, safe, and warm. There would appear to be no sound, there is an aura of calmness and tranquillity, and patients may describe love, joy, and the ability for telepathic communication. Thinking appears faster and there seems to be an acceleration of time.

Two other experiences are common—most patients describe a bright light in the centre of vision and they seem to be travelling down a tunnel towards it. Many patients also describe out of body experiences in which they seem to be observing themselves from a distance. The most striking example of this is a patient who was blind from birth and had never had any visual experience. She was involved in a road traffic incident and when she recovered she had some recollections of an out of body experience, apparently while she was unconscious, in which she could see herself. Some patients describe re-entering their bodies, as if returning from the dead.

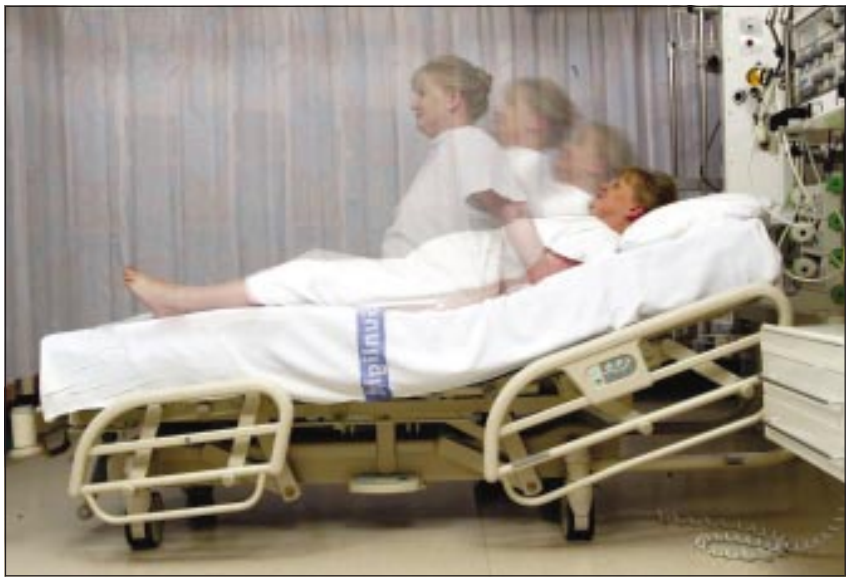
Throughout the programme there is considerable confusion about death, near death, and anaesthesia. Patients are often described as being "clinically dead" and then recovering. This is to misunderstand the definition of death. An important criterion in the certification of death is the irrecoverable cessation of brain function. This definition precludes anaesthesia as clinical death since the brain is fully oxygenated with a normal blood flow and recovery occurs without brain damage; indeed, this definition of death precludes anyone who subsequently recovers.

The programme also states that an isoelectric EEG (electroencephalogram) is an indicator of brain death, which is not correct. It is entirely possible for some neuronal activity to persist, though not in a sufficiently widespread or integrated fashion to be recorded at the surface.

Psychologist Susan Blackmore proposes a purely physical explanation for these events and suggests that the experiences are recollections of what happens as consciousness is lost or as it is regained, but not while unconscious. The induction of endorphins might cause heightened awareness with tranquillity and Dr Blackmore sees no reason to postulate a separation of mind and brain.

On the other hand, Sam Parnia, clinical research fellow at the University of Southampton, and Peter Fenwick, consultant neuropsychiatrist at the University of London, argue that the evidence suggests a separation of mind and brain. They claim that the mind can live on when the brain is dead, suggesting that near death experiences can be retained in the mind and then refixed in the brain as it recovers so that they can be subsequently recalled. This is an interesting concept, but most people would not find it necessary to postulate such a separation between mind and brain to explain the events.

The history of medicine is full of examples of phenomena that at first could not be explained, but for which a purely physical explanation becomes apparent with further understanding of the mechanisms of the brain. This is likely to be the case with near death experiences. We have only to see a skilled showman working his magic to realise how easy it is for the brain to be fooled into thinking the impossible while we are in full possession of our faculties. How much easier, therefore, in circumstances associated with near death experiences.



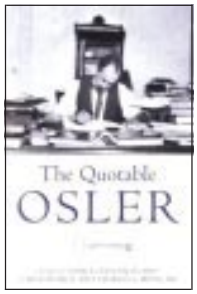
Some patients who have lost consciousness have described out of body experiences

Michael O'Brien *consultant neurologist, Guy's Hospital, London*

Items reviewed are rated on a 4 star scale (4=excellent)

The Quotable Osler

Eds Mark E Silverman, T Jock Murray, Charles S Bryan



American College of Physicians, $30, pp 283
ISBN 1 930513 34 8

Rating: ★★★

Before offering Sir William Osler (1849-1919) the position of professor of clinical medicine at the University of Pennsylvania, the eminent and eccentric doctor and novelist Silas Weir Mitchell was asked by his colleagues to "look him over." Osler subsequently reported that "Dr Mitchell said there was only one way in which the breeding of a man suitable for such a position, in such a city as Philadelphia, could be tested: give him a cherry pie and see how he disposed of the stones. I had read of the trick before, and disposed of them genteelly in my spoon—and got the Chair."

This collection of 812 quotations compiled by three eminent Oslerians, and with a foreword by another, Charles G Roland, is a rich pie indeed—with only a few stones to mar an otherwise totally satisfying feast.

Among personal qualities Osler called for eschewing apathy and arrogance; espousing humility, culture, and humour; and—especially—cultivating equanimity. One of his most quotable phrases is surely "Look wise, say nothing, and grunt. Speech was given to conceal thought." Osler's own good humour is much in evidence here. I especially liked "Beware of the men that call you 'Doc.' They rarely pay their bills."

So far as the practice of medicine is concerned, Osler, a strong proponent of family practice, called family doctors people of noble character who are in the front line of fighting disease, and who emphasise care for the patient, not the disease. He noted the need for doctors to tolerate uncertainty, and believed that "errors in judgment must occur in the practice of an art which consists largely of balancing probabilities." He also averred that physicians "are here not to get all we can out of life ourselves, but to try to make the lives of others happier."

Some of the few stones in the pie have to do with contradiction: urging routine at one point, and elsewhere describing it as malign. Others are to do with ageism: "Evil mistakes and drivel are mostly produced by sexagenarians"; and sexism: "A larger proportion of women than of men are unfit for practice."

Moreover, even though there are good words to be found on almost every page, Osler warned "beware of words—they are dangerous things. They change color like the chameleon, and they return like a boomerang."

The essay by Richard L Golden describes Osler as "among the most esteemed and distinguished physicians in the history of medicine. His influence, clinical, educational, and literary, was global and his legacy remains strong … and [he] left a vast written record, more than 1600 items encompassing medical, philosophical, educational and historical papers, essays and books."

The Quotable Osler is a distillation of and a tribute to that prodigious and eclectic output. It is a source of wisdom, common sense, and culture. No wonder Silas Weir Mitchell gave Osler the thumbs up for his move to Philadelphia. Doctors should do the same for this book.

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Rosalind Franklin: The Dark Lady of DNA

Brenda Maddox

Harper Collins, £20, pp 400
ISBN 0 00257149 8

Rating: ★★★

Rosalind Franklin, the biophysicist whose work provided the scientific support for Watson and Crick's development of the structure of DNA, has remained a mystery, her opinions and motivations hidden. Was she—as described by her colleague Maurice Wilkins, who shared the Nobel prize with Watson and Crick—the "dark lady," a bellicose spinster who could not collaborate and resented their work and originality? Was her work ignored because it was insignificant or because she was antisocial? Or was she a brilliant scientist and feminist, a sacrificial victim, her work overlooked and her progress diminished because she was an outsider who didn't fit into the "old boy" network? The truth, of course, lies somewhere in between.

Franklin was the eldest daughter of a wealthy, upper middle class, established British Jewish family, which owned banks and a publishing company. Believing that her parents thought her less important than her three brothers, she none the less excelled at school and at Cambridge University. A brilliant physicist, she worked for the British government, doing original and important work on the nature of different coals, using *x* ray crystallographic techniques.

After the second world war, she spent several years in Paris directing research using *x* rays to study coal and other solids. Gaining a strong scientific reputation, she was invited to King's College in London to work with Maurice Wilkins to use the new techniques of *x* ray crystallography to define large biological molecules such as the RNA of the tobacco mosaic virus and DNA. Her painstaking and precise work created several images of DNA that proved that it had a helical structure. While the "race" was on to develop a model of DNA before anyone else, Watson and Crick needed the structural data that her *x* ray images and research could provide, and "borrowed" her results. Not receiving credit or acknowledgment for her contributions, she continued to work on the structure of RNA viruses, establishing important insights until her death from ovarian cancer aged 37. Four years later Watson, Crick, and Wilkins received the Nobel prize, failing to acknowledge her contributions.

This biography describes the world of the burgeoning biological research fields of the late 1940s and 1950s—the collegiality, the conferences, the networks of friends, lovers, mentors and students, the competitiveness, and the search for funding that all made up the world of science and that are all reminiscent of research today.

Undoubtedly an excellent and productive researcher, producing 5 to 10 papers a year, Franklin could be uncompromising and demanding, but no more demanding of others than she was of herself. She had no personal need for academic titles or positions, but instead just looked for funding for her research. She was happy and secure in Paris, but after returning to English science, she found herself misunderstood, alienated, separated, and ignored.

Brenda Maddox painstakingly steers a course to show a woman who was passionate in her work, accomplished in her science, who had close friends, students, and mentors, and yet whose personal motivations and desires remain unclear. But how can her personal strengths or weaknesses have occasioned her lack of recognition? Must one be a good team player to be a good scientist? How can she be vilified for being a private, yet uncompromising and demanding person, when her colleagues and mentors were as individualistic as she was? Would she too have won the Nobel prize had she lived? We will never know, but after reading this book, Rosalind Franklin becomes a complete woman and scientist, a role model, and a laudable mentor, no longer a shadowy, embittered spinster or ennobled martyr.

Jo Ann Rosenfeld *assistant professor of medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland*
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NETLINES

● The UK Diploma in Intensive Care Medicine is a fairly new exam. It therefore may seem hard to know what to expect from it or how to prepare for it as so far relatively few people have sat it. James Austin is one who has, and at www.dicm.co.uk/ he has put together a site offering advice to future candidates, based on his own experiences of qualifying, studying, and sitting for the 2002 exam. Although much of what he says is specific to the DICM, there are also some useful nuggets that might help those preparing for other postgraduate medical examinations.

● Online teaching and educational resources are fast becoming standard tools to advance learning and knowledge. Visual specialties such as radiology are well suited to web publishing, and the Harvard Medical School Joint Programme in Nuclear Medicine (www.jpnm.org/elr.html) offers an important collection of teaching cases, catalogued by various features. In addition, there is an interesting images collection as well as a section devoted to reports. There are also links to associated departments, but the online cases will probably attract most interest.

● For a slick site on the herpes virus check out the International Herpes Management Forum (www.ihmf.org). It is an attractively designed site packed with data, easily signposted from the home page. Features include a journal, guidelines, and a resources section.

● VacciNews (www.vaccinews.com) is the official website of the Asia-Pacific Vaccination Council, produced jointly with Merck Sharp & Dohme. It bristles with avenues of information available from the home page. Features include disease and vaccination data, a newsletter, frequently asked questions, and an events, meetings, and seminars listing. The style is relaxed but informative and good site design allows unhindered access to the material.

● The Thrombosis Interest Group of Canada has produced a good series of guidelines for the management of thrombosis and associated conditions (www.tigc.org/eguidelines/guidelines.htm). The collection covers common clinical scenarios that span a number of specialties and the site is available in French as well as English. This is an excellent reference point not just for Canadians but for the global health community.

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We welcome suggestions for websites to be included in future Netlines. Readers should contact Harry Brown at the above email address.

Tabloids blame asylum seekers for GP shortages


WIDOW, 88 TOLD BY GP: MAKE WAY FOR ASYLUM SEEKERS

The UK tabloids have been fighting their latest war on asylum seekers on many fronts but one of the main battles has been about access to health services. On 27 January the *Express* claimed that a general practice in Birmingham was close to breaking point after 600 asylum seekers arrived to enrol. Last year the *Daily Mail* claimed that a medical centre in Derby was being given over to asylum seekers, forcing existing patients to go elsewhere. But perhaps the most emotive of this kind of story was on the front page of the *Mail on Sunday* on 19 January. The paper claimed that an 88 year old widow had been struck off by her general practice to make way for asylum seekers.

The *Mail on Sunday* claimed that the widow, Lydia Perry, from Stoke-on-Trent, was "summoned to the surgery to be told by her GP, Uday Pathak, to find a new doctor." The paper said she was one of more than 30 patients who had been struck off because "health officials were insisting that GPs take on asylum seekers from a neighbouring hostel."

Dr Pathak was reported as "being unhappy about removing Mrs Perry from his list of patients." The paper quoted a letter he had written to local health officials, which read: "Because of the shortage of GPs in the area, patients have been allocated at the discretion of the health authority and I have been allocated many patients in the last six months.

"Asylum seekers have problems of their own, ie communication, it takes nearly 35 to 40 minutes to establish their problems. There is considerable delay in the running of the surgery. My list size is too much to cope with. The health authority is always keen to allocate patients and asylum seekers without considering the situation on the ground."

Nicola Plumb, a spokesperson from the Department of Health, said: "It wasn't actually anything to do with asylum seekers. He was just a GP reducing his list."

Cath Hayward at North Staffordshire Health Authority confirmed this. "It's not true. Of course there is no end of headaches because we'll have to spend our entire lives refuting it."

Pauline Parkinson, director of primary care at North Stoke Primary Care Trust, said she had wearily dealt with a barrage of accusations following the article's publication. She said that Dr Pathak had been struggling with numbers of patients, especially after a local nursing home allocated patients to the practice. He had decided to reduce his practice, by first reducing his practice area, with agreement from the authorities and was negotiating with patients outside the boundary to move to neighbouring GPs. "GPs get patients allocated to them, and there are two allocation processes," explained Mrs Parkinson. "One is for patients who are moving around all the time, the other is for asylum seekers applying for practices. He may well have had a small allocation of asylum seekers, but that wasn't the reason why she [Mrs Perry] was taken off the list. It had nothing to do with asylum seekers."

Dr Pathak was unavailable for comment at the time the *BMJ* went to press.

David Dillon of the *Mail on Sunday* said that the story was based not only on Dr Pathak's letter but also on what the family had said to the paper. But Mrs Parkinson said: "The family of the lady objected to her being used as a political football." And on 21 January the Stoke-on-Trent *Sentinel* reported that Mrs Perry's daughter, Maureen Currell, had complained to the *Mail on Sunday*. The *Sentinel* quoted Mrs Currell as saying: "We have nothing against asylum seekers and the care that we have had from Dr Pathak has been wonderful. We can understand why the doctor felt he had to do what he did. Our argument is with the system which has left too few doctors on the ground to cater for all the patients needing care." She added: "The fact is that mum has been removed to make way for another pensioner from a nursing home—not an asylum seeker—although that may be an issue in the future."

This was, then, not really so much a story about asylum seekers at all, but a story about GP shortages, which the BMA warned this week were worsening. But in blurring the two issues, the *Mail on Sunday* has ridden high on the current wave of tabloid hysteria about immigration, for which some papers have been much criticised. On Monday campaign groups staged a protest outside the offices of the *Mail on Sunday* and its sister paper the *Daily Mail* over its coverage of asylum seeker issues.

Mareeni Raymond *medical student, Royal Free and University College London*

PERSONAL VIEW

Us and them

Mental health has recently been big news again. Two entirely unrelated incidents have rekindled the media's interest in a topic that, for most of the year, receives scant attention. In both cases the suspects had histories of mental illness which, long before either stand trial for their alleged crimes, were discussed exhaustively in the national press.

Mental health is, with the partial exception of HIV, almost unique among health issues in the media. To understand this, it is important first to be aware of how media organisations work. Almost all UK media are businesses. They exist to make their proprietors money. Most media make the majority of their money from the advertising space they sell to other businesses which are, in effect, the paying customers to whom we, the audience, are the delivered product.

Advertising aims to address its audience as consumers, appealing to the aspirations and fears we have for ourselves and our families. It is in the economic interest of news organisations to appeal to that same ethic in the editorial content of the media they control.

Almost all media content can be classified into two kinds: "us" and "them." In "us" coverage, the story is about things that happen to "ordinary" people: those with whom the presumed audience identifies. Most health coverage comes under this category. News about cancer, heart disease, or the ongoing woes of the NHS are predicated on the fact that these could personally affect any one of us, or our families, tomorrow.

"Them" coverage is about topics that are presumed not to be about the "average" consumer. Issues such as immigration or social security fall squarely into this category. Asylum seekers and poor people may have an impact on the presumed audience (they cost "us" more in taxes; they might mug or beg from us in the street; we might even pity them), but they are not a part of that audience. The same is true of most coverage of mental health. With notable exceptions, the assumption behind news stories about mental illness is that it is something that affects others. We, the audience, may feel sorry for them or may be afraid of them, but they are most certainly not "us."

To understand the way in which mental health is mediated, then, it is often more helpful to look at the way in which issues such as race, rather than, say, cancer, are covered. As many studies of racism in the media have shown, commonplace myths about black and minority ethnic groups (not least those surrounding dangerousness and mental illness) are often painfully close to the surface.

Yet there are signs of change. Black people now form a significant proportion of the audience for, and staff of, many mass media. Their influence, as both consumers and workers, may not have rid the mass media of racism, but it has certainly curtailed some of the worst excesses.

The assumption behind news stories about mental illness is that it is something that affects others

For mental health, progress has been less impressive. Throughout the past decade, care in the community has been vilified widely for bringing dangerous people closer to "us" and our families. Figures such as Christopher Clunis, who, of course, also happens to be black, and Michael Stone may have hit the headlines (Clunis, who killed Jonathan Zito at a London Underground station, had a history of schizophrenia; and Stone, who murdered Lin and Megan Russell, was reported to have a severe personality disorder). Yet there is scant interest in the effect of community care on non-violent individuals.

The reasons for this are numerous. People with mental illnesses do not easily form coherent communities. Like sexuality, mental illness is something people are often reluctant to identify themselves with in the workplace. It arouses mixed emotions and is hard to empathise with. There is neither sufficient pressure from outside the media, nor enough willingness within, to make it an "us" issue.

Even the most empowered and empathic health correspondents are well aware of what will, and what will not, get past their editors. A story about, say, funding for mental health services, unless it focuses on the issues of dangerousness to other people, has little chance of gaining the same profile as a similar story about funding for cancer or emergency services. It simply would not appeal to that crucial sense of being something affecting "us" directly enough to be newsworthy.

This is a fairly bleak picture. Yet the mental health user movement is growing in self-confidence and media influence, most notably around the debate over the Mental Health Bill. By showing an awareness of the pressures journalists face, and by working as a coherent community, it can begin to change the public discourses that surround mental health.

Andy Bell *director of communications, Sainsbury Centre for Mental Health, London*
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SOUNDINGS

Gadgets for consultants

Calling all consultants! We know you don't buy executive toys but just take a look at our 2003 range of useful gadgets.

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Interested? Gadgets for consultants are classed as "medical equipment" so they cost 20 times as much as identical gadgets sold to the public. But we think you'll agree they're worth it.

James Owen Drife *professor of obstetrics and gynaecology, Leeds*